WISCONSIN MEDICAID
PRIOR AUTHORIZATION / PHYSICIAN ATTACHMENT (PA/PA) COMPLETION INSTRUCTIONS

Complete the Prior Authorization/Physician Attachment (PA/PA), HCF 11016, including the Prior Authorization Request Form (PA/RF), HCF 11018, and submit it by fax to (608) 221-8616. Providers also have the option of submitting PA requests by mail to the following address:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

Providers with questions about completing PA requests should call Provider Services at (800) 947-9627 or (608) 221-9883.

To obtain copies of PA forms, providers have the following options:

- Download and print a copy of the form from the Medicaid Web site.
- Photocopy the attachment.
- Order copies by writing to Wisconsin Medicaid. Include a return address, the name of the form, and the number of copies needed. Mail the request to the following address:

  Wisconsin Medicaid
  Form Reorder
  6406 Bridge Rd
  Madison WI 53784-0003

SECTION I — RECIPIENT INFORMATION

Element 1 — Name — Recipient
Enter the recipient's last name, first name, and middle initial. Use the Medicaid Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 2 — Date of Birth
Enter the recipient's date of birth in MM/DD/YYYY format.

Element 3 — Recipient Medicaid Identification Number
Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters.

SECTION II — PROVIDER INFORMATION

Element 4 — Name — Performing Provider
Enter the name of the provider who would perform/provide the requested service/procedure.

Element 5 — Performing Provider's Medicaid Provider Number
Enter the eight-digit Medicaid provider number of the physician performing the service.

Element 6 — Telephone Number — Performing Provider
Enter the telephone number, including the area code, of the provider performing the service.

Element 7 — Name — Ordering / Prescribing Physician
Enter the name of the referring/prescribing physician in this element.

SECTION III — SERVICE INFORMATION

The remaining portions of this attachment are to be used to document the justification for the requested service/procedure.

1. Complete Elements A through C.
2. Sign and date the PA/PA (Element D).

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s). Providers should amend a PA request before it expires if services are significantly different from or greater than those services prior authorized.